

Financing Vaccination of Children and Adolescents

**UPDATE ON THE
NATIONAL VACCINE ADVISORY COMMITTEE
(NVAC) VACCINE FINANCING
RECOMMENDATIONS OF 2008**

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SEPTEMBER 11, 2012 – NVAC DAY 1**

Background

Process Highlights

NVAC meeting
presentations

Handout –
recommendations
Pediatrics Vol 124,
Suppl 5, Dec 2009,
S559-S562

- Oct 2006 – Vaccine Financing Working Group
 - Establish process obtaining stakeholder input regarding challenges to creating optimal approaches to vaccine financing in public and private sectors
- April 2008 – Stakeholder Meeting
 - Informational presentations and feedback on proposed recommendations, including identification of preferred solutions so support child and adolescent vaccine delivery
- Sept 2008: Recommendations
 - Adopted at public meeting of full NVAC committee – to ensure all children/adolescents have access to all routinely recommended vaccinations without financial barriers
- 2009 – 2010: Follow Up
 - Cost estimates (Feb) , Implementation plan update (Sept), Pediatrics supplement (Dec)
http://pediatrics.aappublications.org/content/124/Supplement_5.toc
 - Stakeholder activity update (Feb 2010)

Structure of recommendations

- Block 1 Vaccines for Children (VFC) and the underinsured
- Block 2 Vaccine administration reimbursement
- Block 3 Business practices in private provider offices
- Block 4 Health insurance plans
- Block 5 Activities of federal agencies and offices
- Block 6 Activities of state agencies and offices
- Block 7 Adolescent vaccination in complementary venues

Block 1 VFC and underinsured

- Recommendation #1: Vaccines for Children program (VFC) should be extended to include access to VFC eligible underinsured children and adolescents receiving immunizations in public health department clinics
 - In 2012, the 61 VFC Programs were provided with HHS-approved guidance for making deputization arrangements between Federally Qualified Health Centers or Rural Health Clinics and public health departments to serve VFC-eligible underinsured children.

Block 2 (Rec 2-5) Admin reimbursement

- *Rec #2: VFC should be expanded to cover vaccine administration reimbursement for all VFC-eligible children and adolescents.*
- Rec #3: CDC & CMS should annually update, publish, and disseminate actual Medicaid vaccine administration reimbursement rates by state
 - CMS website
- Rec #4: CMS should update the maximum allowable Medicaid administration reimbursement amounts for each state and include all appropriate non-vaccine related costs as determined by current studies
 - June 2012, CMS published a proposed rule (CMS-2370-P) that included an updated fee schedule for the VFC program. CMS is in the process of finalizing that rule, with the Final Rule expected to be published in October.
 - VFC statute calls for the calculation of the administration fee based on Medicaid costs. Because Medicaid cost data is not available, CMS has used physician cost data that is used by Medicare for the Medicare physician fee schedule.

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- Rec #5: Increase the federal match (i.e. a larger federal proportion) for vaccine administration reimbursement in Medicaid to levels for other services of public health importance
 - Medicaid Bump (ACA): Any change to the Medicaid federal match requires Congressional action. Included in the Affordable Care Act is a provision to increase payment to primary care providers. That provision explicitly identified the immunization administration codes for increased payments. CMS published proposed rulemaking on this provision in June 2011 and is the final rule is expected to be published in October.

Block 3 (Rec 6-9)

Business practices in private provider offices

- Rec #6: AMA's RVS Update Committee (RUC) should review its RVU coding to ensure that it accurately reflects the non-vaccine costs of vaccination including the potential costs and savings from the use of combination vaccines – Jan 2011 multiple antigen x-codes released*
- Rec #7: Vaccine manufacturers and third-party vaccine distributors should work with providers on an individual basis to reduce the financial burden for initial and ongoing vaccine inventories, particularly for new vaccines – manufacture programs
- Rec #8: Professional medical organizations should provide their members with technical assistance on efficient business practices associated with providing immunizations – medical societies
- Rec #9: Medical providers, particularly in smaller practices, should participate in pools of vaccine purchasers to obtain volume ordering discounts – e.g. physician buying groups

*VFC continues to pay by vaccine (vs by antigen) as per statute

Block 4 (Rec 10-13) Health insurance plans

- Recommendation #10: Professional medical organizations, and other relevant stakeholders should develop and support additional employer health education efforts – e.g. employer-based programs, influenza Employer WG
- Recommendation #11: Health insurers and all private healthcare purchasers should adopt contract benefit language that is flexible enough to permit coverage and reimbursement for new or recently altered ACIP recommendations as well as vaccine price changes that occur in the middle of a contract period –model contract language, educ materials/resource guides
- Recommendation #12: All public and private health insurance plans should voluntarily provide first-dollar coverage (i.e., no deductibles or co-pays) for all ACIP-recommended vaccines and their administration for children and adolescents – ACA
 - Shortridge EF, Moore JR, Whitmore H, O'Grady, MJ, Shen, AK. The policy implications of first-dollar coverage: a qualitative examination from the payer perspective. *Public Health Reports*. 2011;126;394-9.
- Recommendation #13: Insurers and healthcare purchasers should develop reimbursement policies for vaccinations that are based on methodologically sound cost studies of efficient practices.

Block 5 (Rec 14-20)

Activities of federal agencies and offices

- Rec #14: Congress should request an annual report on the 317 Program
 - CDC has provided its professional judgment in response to Congressional appropriations language.
 - In its most recent professional judgment for estimated funding needs of the Section 317 Program to support a comprehensive immunization program that supports optimum state and local operations funding, CDC operations funding, and vaccine purchase needs, CDC provided the following estimates:
 - State and local program operations: \$555.8 million
 - National program operations: \$139.3 million
 - Vaccine purchase needs: \$218.6 million
 - Routine uninsured: 206.1 million
 - Time-sensitive public health needs (e.g. outbreak response, school-locate flu vaccination): \$12.5 million

Cont.

- Rec #15: CDC and CMS should continue to collect and publish data on the costs and reimbursements associated with public and private vaccine administration according to NVAC standards for vaccinating children and adolescents
 - Numerous published papers
- Rec #16: NVPO should calculate the marginal increase in insurance premiums if insurance plans were to provide coverage for all routinely ACIP-recommended vaccines
 - Jun 2009
- Rec #17: NVAC should convene one or more expert panels representing all impacted stakeholders to consider whether tax credits could be a tool to reduce or eliminate underinsurance
 - ACA requires health plans to cover at no cost the ACIP recommended vaccines adopted by CDC when provided by an in-network provider. This should significantly reduce underinsurance for vaccination as the health insurance reforms are fully implemented over the next several years.

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- Recommendation #18: CDC should substantially decrease the time from creation to official publication of ACIP recommendations
 - CDC has made substantial progress in improving timely publication of CDC-adopted ACIP recommendations in *MMWR* through the use of the Policy Note format (*i.e. simpler format and process*).
- Recommendation #19: Congress should expand Section 317 funding to support the additional national, state and local public health infrastructure needed for adolescent & childhood vaccination programs
 - As resources have become available, CDC has made investments in improving the public health infrastructure for childhood and adolescent vaccination programs, including:
 - Reaching more children and adolescents with vaccination, American Recovery and Reinvestment Act (ARRA), FY 2009
 - Strengthening capacity for vaccinating school-age children, Prevention and Public Health Funds (PPHF), FY 2011 and 2012
 - Improving vaccine storage and handling, PPHF FY 2012
 - Improving immunization information systems and technologies, ARRA and HITECH, FY 2009 and PPHF FY 2011 and 2012

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- Recommendation #20: Continue federal funding for cost-benefit studies of vaccinations targeted for children and adolescents.
 - CDC updated the cost-benefit of the routine childhood immunization schedule (Zhou F, Economic Evaluation of the Routine Childhood Immunization Program in the United States, 2009. Pediatric Academic Societies' Annual Meeting, Boston, MA, April 28-May 1, 2012)
 - CDC is conducting cost-benefit analysis of the routine adolescent immunization schedule.

Block 5 (Rec 21-22)

Activities of state agencies and offices

- Rec #21: State, local and federal governments along with professional organizations should conduct outreach to physicians and non-physician providers who currently serve VFC-eligible children and adolescents to encourage these providers to participate in VFC
 - E.g. H1N1 efforts expanded outreach to new providers

Cont.

- Recommendation #22: States and localities should develop mechanisms for billing insured children and adolescents served in the public sector
 - Thirty-five immunization grantees have been or will be funded to develop billing systems for vaccines provided in public health clinics (ARRA FY 2009, PPHF FY 2011 and 2012).
 - Project includes collaboration with AHIP to provide technical assistance.

Block 7 (Rec 23-24)

Adolescent vaccination in complementary venues

- Rec #23: Ensure adequate funding to cover all costs (including those incurred by schools) arising from assuring compliance with child and adolescent immunization requirements for school attendance
 - As more states add vaccine requirements they take into consideration
- Rec#24: Promote shared public and private sector approaches to help fund school-based and other complementary-venue child and adolescent immunization efforts
 - Pilot programs

Thanks

- NVAC Vaccine Finance Working Group, NVAC
- NVAC partners
 - Consumers
 - Distributors, purchasers
 - Manufacturers
 - Federal, state, local public health
 - Employers, payers, health insurers
 - Healthcare providers and organizations
- Kristin Pope, CDC
- Mary Beth Hance, CMS